126997

STATE OF MICHIGAN
IN THE SUPREME COURT

RALPH KROCHMAL,

Plaintiff-Appellee,

v

PAUL REVERE LIFE INSURANCE COMPANY,

Defendant-Appellant.

_____ /

Supreme Court No. 126997

Court of Appeals No. 242776

Wayne County Circuit Court No. 00-4378-CK

BRIEF OF AMICUS CURIAE, COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE SERVICES, IN OPPOSITION TO APPLICATION FOR LEAVE TO APPEAL

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Statement of Issues Presented

I. **The Michigan Court of Appeals has ruled that including a requirement that policyholders submit "satisfactory proof of loss" does not grant insurers discretion to deny claims. Its decision is supported by the requirement that ambiguous insurance contracts be construed against the insurer, by the Michigan Insurance Code's use of the term "satisfactory proof of loss" to refer to materials submitted rather than a standard of review, by Michigan law relating to contracts requiring "satisfactory" performance, and by the law in other jurisdictions that have considered the issue. Was the Court of Appeals correct in deciding that merely requiring "satisfactory proof of loss" is insufficient to grant insurers discretion to deny claims?**

Appellant Paul Revere answers: "No"

Appellee Krochmal answers: "Yes"

Amicus Curiae Commissioner answers "Yes"

II. **Whether insurance policies are reasonable is a question reserved to the discretion of the Commissioner of the Office of Financial and Insurance Services. The Commissioner has not been presented with an opportunity to review an insurance policy that clearly grants the insurer discretion to deny claims. Should this Court agree to hear this case, which is based on Appellant Paul Revere's argument that the ambiguous language of its policy grants it discretion to deny claims, before the Commissioner has an opportunity to determine whether such a provision is reasonable under the Michigan Insurance Code?**

Appellant Paul Revere answers: "Yes"

Appellee Krochmal answers: "No"

Amicus Curiae Commissioner answers "No"

Order Appealed From

Appellant Paul Revere Life Insurance Company ("Paul Revere") seeks leave to appeal the Court of Appeals' May 20, 2004 Order, which affirmed the Circuit Court's judgment in favor of Appellee, Ralph Krochmal. For the reasons stated below, the Commissioner of the Office of Financial and Insurance Services ("OFIS"), submits this brief as amicus curiae in opposition to Paul Revere's request.

Statement of Facts and Material Proceedings

Paul Revere provided disability insurance coverage to Mr. Krochmal. The Paul Revere policy (the "Policy") provided that benefits will be paid after Paul Revere receives "satisfactory written proof of loss." (See, Policy, p 16, Exhibit 2 to Paul Revere's Application).

On May 4, 1996, Mr. Krochmal applied for disability benefits under the Policy. Paul Revere provided benefits for over three years. In 1999, Paul Revere required Mr. Krochmal to be reexamined. After this examination, Paul Revere denied Mr. Krochmal's claim and ceased paying benefits under the Policy.

Mr. Krochmal commenced an action in Wayne County Circuit Court, alleging that Paul Revere breached its insurance contract by ceasing payment of benefits. The Circuit Court ruled that: (1) the Policy is not governed by the Employment Retirement Income Security Act of 1974 ("ERISA"),[1] and (2) that Paul Revere had improperly determined that Mr. Krochmal was not eligible for benefits. Paul Revere filed a timely appeal to the Michigan Court of Appeals.

On appeal, Paul Revere argued again that this matter is governed by ERISA. Additionally, it argued that, regardless of what law governed the Policy, its decision to terminate benefits was within its discretion and could not be reversed unless it was "arbitrary and capricious." The Court of Appeals rejected both arguments.

The Court of Appeals held that the Policy was not governed by ERISA and that, under Michigan law, Paul Revere's benefit decision was subject to de novo review by a court.[2] The Court of Appeals did state that, if the issue were one of first impression, it would have held that under the Policy's language, specifically the requirement of "satisfactory written proof of loss," Paul Revere's benefit decision was only subject to reversal if it was arbitrary and capricious.

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[1] 29USC 1001, et seq.

[2] *Krochmal v Paul Revere Life Ins Co,* 262 Mich App 115; 684 NW2d 375 (2004).

But, the Court of Appeals deferred to the earlier decision in *Guiles v Univ of Michigan Bd of Regents*, which held that policy language requiring "satisfactory proof of loss" does not grant an insurer discretion to deny claims.[3]

Paul Revere filed an application for leave to appeal to this Court. On June 17, 2005, this Court directed the Clerk to schedule oral argument on Paul Revere's application and directed the parties to submit supplemental briefs. The Court specifically directed the parties to address whether *Guiles* was correctly decided. As explained below, the *Guiles* court was correct, and the Commissioner respectfully requests that this Court refuse to grant leave.

Argument

I. The *Guiles* court's decision that the policy language at issue did not vest the insurer with discretion in making benefit decisions was correct because the language failed to clearly vest discretion in the insurer.

A. The policy language failed to clearly vest the insurer with discretion to deny benefits.

The *Guiles* court determined that language like that in the Policy did not clearly grant the insurer discretion to deny claims. In this regard, the *Guiles* court stated that reserved discretion was not the norm and the language at issue was not clear enough to impart such discretion to an insurer:[4]

> Defendant submits that because the plan requires that a claimant submit "satisfactory proof" of total disability, the university reserved to itself complete discretion to determine eligibility. We find this argument disingenuous and accordingly reject it. Under *Firestone*, discretion is the exception, not the rule. [citation omitted]. . . . In this case, the language relied on by the defendant does not clearly imply that the university shall have the last word on benefits.

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[3] *Guiles v Univ of Michigan Bd of Regents,* 193 Mich App 39, 47 n 4; 483 NW2d 637 (1992).
[4] *Guiles v Regents of Univ of Michigan, supra,* 193 Mich App at 47, n 4:

The *Guiles* court was correct in rejecting the plaintiff's argument and correct in focusing on the lack of clarity in the language relied upon. Its decision was consistent with the time-honored principle of *contra proferendum* -- that ambiguous contract language is to be construed against the drafter.

Numerous Michigan courts have applied the *contra proferendum* doctrine to insurance contracts. Indeed, this Court, when considering ambiguous insurance contracts, has used strong language to describe the application of *contra proferendum*, making it clear that not only must the policy be construed in favor of the insured but it must construed as favorably as possible. This Court has stated that "[i]f there is any doubt or ambiguity with reference to a contract of insurance which has been drafted by the insurer, it should be construed most favorably to the insured."[5] It has also made clear that the construction least favorable to the drafting insurer is appropriate, stating, "[a]n insurance policy must be construed most strongly against the insurer."[6] This strong position reflects the fact that insurance, while a private for-profit enterprise, "is vitally affected with the public interest."[7] Because of the "special relationship between an insurer and its insured and . . . due to the quasi-public nature of the insurance industry, there is a duty for insurance companies to deal fairly with their customers apart from any contractual obligations owed."[8] Analyzing the policy language at issue in this framework, it is clear that the *Guiles* court correctly determined that the language did not grant discretion to the insurer.

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[5] *Gorham v Peerless Life Ins Co,* 368 Mich 335, 343; 118 NW2d 306 (1962).
[6] *Mondue v Lincoln Mut Cas Co,* 283 Mich 353, 358; 278 NW 94 (1938).
[7] *Arrigo's Fleet Service, Inc v AETNA Life & Cas Co,* 54 Mich App 482, 486; 221 NW2d 206 (1974).
[8] *Hearn v Rickenbacker,* 140 Mich App 525, 528; 364 NW2d 371 (1985).

The Policy's language is ambiguous. An insurance policy is ambiguous when it may reasonably be understood in different ways.[9] It is unambiguous if its language can only be interpreted one way.[10] Thus, in order for Paul Revere to contractually assume the type of discretion it is now asserting that it has, the language of its policy must not be susceptible to any reasonable interpretation other than that the "satisfactory written proof of loss" language vests complete discretion for benefit determinations in Paul Revere. This language can, in fact, be understood in different ways. For example, the language could be understood to require that certain types of material be submitted, such as accident reports or medical evaluations, or that the proof of loss submitted be satisfactory to a reasonable person. Indeed, both the Michigan Insurance Code and Michigan contract law suggest, if not mandate, a different construction of the language.

B. Paul Revere's construction of its policy is inconsistent with the Michigan Insurance Code's use of the same language.

The Insurance Code of 1956, MCL 500.100 *et seq*, does not explicitly define the term "satisfactory proof of loss." However, the Code does use that language. Section 2006(3) of the Code, which requires an insurer to act on claims promptly and imposes penalties for failure to do so, requires that: [11]

> An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within 30 days.

This section "creates a statutory duty on the part of an insurer with the benefit of such duty running to the insured to inform the insured of what constitutes a satisfactory proof of

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[9] *Raska v Farm Bureau Mut Ins Co,* 412 Mich 355, 362; 314 NW2d 440 (1982).
[10] *Raska v Farm Bureau Mut Ins Co, supra* 412 Mich at 362.
[11] MCL 500.2006(3)(emphasis added)..

loss."[12] Thus, the Code uses the term "satisfactory proof of loss" to refer to the materials that an insurer requires for processing a claim. In every claim, the insurer has a statutory duty to inform its insured what "satisfactory proof of loss" entails. A "satisfactory proof of loss" is merely one that contains all the materials required by the insurer. It is not one that meets the subjective, undisclosed satisfaction threshold of the insurer.

Defining the term "satisfactory proof of loss" in accordance with the Insurance Code is appropriate. This Court has held, in cases involving mandatory insurance, that "[t]he policy and the statutes relating thereto must be read and construed together as if the statutes were part of the contract."[13] While the Policy is not mandatory insurance, the duty imposed on insurers is and this Court should construe the policy consistent with the statute. The statute and the policy language both deal with the same topic – when claims will be paid. The Policy uses the same language as the statute and does not provide any alternative definition for the term "satisfactory written proof of loss." Thus, a reasonable construction of "satisfactory proof of loss" as used in the Policy arrives at the same meaning it has been given in the Code, i.e. the materials required by the insurer to process a claim. Given that the goal of construing the Policy is to arrive at the construction most favorable to the insured, resort to the Code, which provides a reasonable construction that is favorable to the insured, is appropriate in this case.

C. Under Michigan contract law, the policy language at issue here does not vest discretion in Paul Revere and its benefit decisions are subject to judicial review.

Even if this Court determines that the "satisfactory proof of loss" language in the Policy means that the proof of loss provided must be satisfactory to Paul Revere, Paul Revere's benefit decision is still reviewable and is not entitled to the deference it seeks. In *US Heat & Power*

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[12] *Dellar v Frankenmuth Mut Ins Co,* 173 Mich App 138, 143; 433 NW2d 380 (1988).
[13] *Rohlman v Hawkeye-Security Ins Co,* 442 Mich 520, 525, n 3; 502 NW2d 310 (1993).

Corp v Lachmann, this Court made clear that Michigan law recognizes two types of contracts where one party must perform to the other's satisfaction.[14] While some contracts, usually involving personal taste or sensibility, do allow the party unfettered discretion to decide whether it is satisfied, contracts where the party is supposed to act fairly are subject to de novo review:[15]

> In the other class the promisor is supposed to undertake that he will act reasonably and fairly, and found his determination on grounds which are just and sensible, and from thence springs a necessary implication that his decision in point of correctness and the adequacy of the grounds of it are open to consideration and subject to the judgment of judicial triers.

This Court should consider the context of the insurance relationship between Paul Revere and Mr. Krochmal. As noted above, insurance companies are under a special duty to deal fairly with their customers.[16] Thus, insurance contracts, like the Policy, are exactly the type of contract where a party is obligated to deal fairly and where judicial review of decisions related to satisfactory performance is warranted.

Additionally, which type of contract a given agreement is "must depend on the special circumstances and the question must be one of construction."[17] Applying the rules of construction to the Policy reveals that, if the Policy is a satisfaction contract at all, it is of the second type, and Paul Revere's decision about whether it was satisfied is subject to judicial review. Paul Revere is not entitled to the extraordinary deference it claims.

The only language addressing the issue in the Policy is the single statement that benefits will be paid upon submission of "satisfactory written proof of loss." The Policy does not define

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[14] *US Heat & Power Corp v Lachman,* 235 Mich 75, 77; 209 NW 187 (1926) (*quoting, Wood Reaper & Mowing Machine Co v Smith,* 50 Mich 565; 15 NW 906 (1883)).
[15] *US Heat & Power supra,* 235 Mich at 77-78 (*quoting, Wood Reaper & Mowing Machine Co v Smith,* 50 Mich 565; 15 NW 906 (1883)).
[16] *Hearn v Rickenbacker,* 140 Mich App at 528.
[17] *US Heat & Power supra,* 235 Mich at 77 (*quoting, Wood Reaper & Mowing Machine Co v Smith,* 50 Mich 565; 15 NW 906 (1883)).

the meaning or effect of the requirement for satisfactory proof. Given that Michigan law explicitly recognizes that contracts requiring satisfactory performance can be of either class, this language alone cannot answer the question.

No other sections of the Policy provide any support for the position that the Policy is one of the first class of satisfaction contracts and unreviewable. Indeed, other language in the Policy suggests that the requirement of satisfactory proof of loss is part of the second class of satisfaction contracts and subject to review. Other sections of the Policy use language that, while still not clearly imparting unfettered discretion on Paul Revere, seem to give its judgment on other issues more weight. For example, the supplemental social insurance benefit rider attached to the Policy provides that the written proof of entitlement to that benefit "must be satisfactory to [Paul Revere]." (Policy, Exhibit 2 to Paul Revere's Application, Supplemental Social Insurance Benefit Rider). While this language does not clearly vest Paul Revere with discretion in making decisions, it is at least clear about who must be satisfied. It places more emphasis on Paul Revere's satisfaction than the language at issue in this case. Accordingly, a reading of the entire policy reveals that Paul Revere does not have unreviewable discretion when making benefit decisions.

Since it is reasonably possible to read the Policy as not being part of the first class of satisfaction contract, there is, at the least, an ambiguity about what type of contract it is.[18] Because of this ambiguity, the Policy should be construed against Paul Revere and most favorably to Mr. Krochmal.[19] The most favorable construction of the Policy is that it does not afford Paul Revere discretion in determining whether the proof of loss submitted is "satisfactory" and Paul Revere's decision is subject to de novo review.

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[18] *Raska v Farm Bureau Mut Ins Co*, 412 Mich at 362.

[19] *Gorham v Peerless Life Ins Co, supra,* 368 Mich at 343.

D. The *Guiles* court's decision was consistent with the law in other jurisdictions and with the leading commentators.

The *Guiles'* decision was also consistent with the law in other states and with the views of leading commentators.

Other states that have considered similar language, requiring "satisfactory" proof of loss, have concluded that such language does not grant discretion to deny claims.[20] This issue arose in the Texas court of appeals in *State Life Ins Co v Atkins.*[21] In *State Life,* the insurer refused to pay disability benefits because it claimed the insured has not submitted "satisfactory" proof of disability. The court rejected the argument that the contractual requirement of "satisfactory proof of loss" vested the insurer with discretion and held instead that the question of whether proof was "satisfactory" is one for courts:[22]

> It seems there was no stipulation in the policy in regard to the proof other than that it should be "satisfactory." The effect of that stipulation was not to give appellant an exclusive right to determine whether the proof furnished was sufficient or not. Hence, appellant's conclusion that it was insufficient was not binding upon appellee. It was for the court, when appealed to, to say whether it was "satisfactory" or not.

In *Caulfield v Aetna Life Ins Co,* the Pennsylvania superior court reached a similar conclusion.[23] It considered what a consumer was required to do to comply with a provision requiring "satisfactory evidence" of disability.[24] That court observed that the purpose of such requirements was to prevent fraud upon insurers, not to allow the insurer to make arbitrary

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[20] See, e.g., *Caulfield v Aetna Life Ins Co,* 19 A2d 575 (Pa Super Ct 1941); *State Life Ins Co v Atkins, supra,* 9 SW2d 290 (Tex App 1928); *Aetna Life Ins Co v Moyer,* 113 F2d 974 (CA3 1940).

[21] *State Life Ins Co v Atkins, supra,* 9 SW2d 290 (Tex App 1928).

[22] *State Life Ins Co v Atkins, supra,* 9 SW2d at 291.

[23] *Caulfield v Aetna Life Ins Co, supra,* 19 A2d 575 (Pa Super Ct 1941).

[24] *Caulfield v Aetna Life Ins Co, supra,* 19 A2d at 578.

demands.[25] Instead, the court held that the "satisfactory evidence" language required "only such a statement of facts as, if established in court, would, prima facie, require payment."[26]

In *Aetna Life Inc Co v Moyer,* the Third Circuit considered the meaning of policy language that required the insured to provide evidence of disability that was "satisfactory to the Company."[27] The court held that such language meant only that the insured was required to submit legally satisfactory proof and that the insurer did not have discretion to reject competent proof of loss:[28]

> Furthermore, the condition that the evidence be satisfactory to the company can mean no more than that it should be legally satisfactory. The policy does not leave it to the caprice of the company to reject arbitrarily any evidence which might reasonably inform the company of its insured's disability and, hence, its own possible liability.

Thus, when this issue has arisen under the laws of other states, requiring "satisfactory proof of loss" has been ruled insufficient to impart discretion.

The leading commentators agree that the language in the Policy does not grant Paul Revere the discretion it seeks. According to Couch's treatise, a requirement of satisfactory proof of loss cannot mean more than reasonable proof:[29]

> If a policy stipulates that "satisfactory proof" shall be furnished, the insurer cannot demand proof other than what is reasonable and just, and ordinarily such a provision will be considered complied with when there has been furnished such proof as establishes the fact of the loss and of the right of the claimant to recover.

Similarly, Appleman on Insurance provides that a requirement that an insured submit "due proof of disability" does not require any proofs the insurer may desire but only what might

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[25] *Caulfield v Aetna Life Ins Co, supra,* 19 A2d at 578.
[26] *Caulfield v Aetna Life Ins Co, supra,* 19 A2d at 578.
[27] *Aetna Life Ins Co v Moyer*, 113 F2d 974 (CA3 1940).
[28] *Aetna Life Ins Co v Moyer, supra*, 113 F2d at 978.
[29] 13 Couch on Insurance, 2d, § 189:59, p. 189-73.

be necessary in the judgment of a court trying the case and the insurer is not "the final arbiter upon this matter."[30]

E. It would be inappropriate to base this Court's decision on ERISA law, which is based on trust law, and which is itself unsettled on this issue.

In support of its argument, Paul Revere has relied upon federal court cases decided under ERISA. It has failed to cite any cases decided under state insurance law in support of its construction of the Policy. As discussed above, the principles of construction applicable to insurance policies undercut Paul Revere's construction. Additionally, Paul Revere has refused to acknowledge the different context of ERISA, which makes it inappropriate in this situation. Further, Paul Revere has not acknowledged that even the ERISA law, which it claims so clearly makes its case, is unsettled and largely contrary to its position.

1. ERISA is based on principles of trust law and involves fiduciary responsibilities that make it an inappropriate source of guidance in contractual disputes between self-interested parties.

ERISA law is an inappropriate guide for cases involving non-ERISA insurance policies because ERISA benefit decisions are made by trustees who owe fiduciary duties to plan participants. Insurance coverage decisions, on the other hand, are made by insurance companies – self-interested parties to a contract. This distinction renders ERISA law, and cased decided under it, inapposite to this matter.

ERISA is based upon the common law of trusts.[31] Under ERISA, plan administrators, like common law trustees, are fiduciaries of the plan beneficiaries.[32] The statute imposes a strict

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[30] 3-79 Appleman on Insurance Law and Practice (1st ed), § 1446.
[31] *Central States Southeast & Southwest Areas Pension Fund v Central Transport, Inc,* 472 US 559, 569; 105 S Ct 2833; 86 L Ed2d 447 (1985).
[32] 29 USC 1102 (a)(1).

standard of loyalty to plan beneficiaries.[33] In this respect, ERISA requires plan administrators to administer ERISA plans for the sole benefit of the participants and beneficiaries.[34] The only purposes ERISA administrators are allowed to pursue are providing benefits to participants and their beneficiaries and defraying administrative expenses.[35] They do not pursue the profit-maximizing motives of private insurers. Indeed, they are barred from doing so. Violation of this duty can subject an ERISA fiduciary to liability.[36]

Unlike ERISA plan administrators, insurance companies are not fiduciaries of their policyholders. In *Drouillard v Metropolitan Life Ins Co,* the court observed that the relationship between an insurer and its insured is a relationship between "one contracting party to another contracting party, rather than of trustee and *cestui que trust.*"[37] The court recognized that insurance contracts require the utmost of good faith; however, it explicitly rejected the argument that a fiduciary relationship existed:[38]

> We conclude that the [lower] court's instruction that the parties stood at arm's length was correct. There is ample authority for the court's instruction that a fiduciary relationship did not exist and that the parties were related merely as two parties to a contract.

Thus, insurers, like Paul Revere, lack the fiduciary responsibilities imposed on ERISA plan administrators. They operate not for the sole purpose of providing benefits but in order to maximize profits. This places insurers in a position adverse to policyholders making claims, which could provide an incentive to deny valid or questionable claims. This is the opposite of the position occupied by ERISA administrators, who are bound to exercise their discretion for

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[33] *Central States, supra,* 472 US at 570.
[34] 29 USC 1104(a)(1).
[35] 29 USC 1104(a)(1)(A).
[36] 29 USC 1109(a).
[37] *Drouillard v Metropolitan Life Ins Co,* 107 Mich App 608, 621; 310 NW2d 15 (1981) (*quoting,* 3 Couch on Insurance, 2d, § 23:11, p 11.)
[38] *Drouillard v Metropolitan Life Ins Co,* 107 Mich App at 621.

the sole benefit of the participants. In view of the different motivations and duties, ERISA precedent should not guide this Court's decision. Instead, it should rely on Michigan law governing insurance and contracts, which makes clear that Paul Revere's policy does not grant it the discretion it claims.

2. Aside from being inapposite to this case, ERISA law is unsettled in this area and several circuits have held contrary to Paul Revere's position.

In addition to the fact that it is an inappropriate source of authority, ERISA does not provide a settled, uniform answer about how the Policy language should be construed. While Paul Revere has correctly pointed out that the Sixth Circuit has interpreted language similar to that in the Policy to grant discretion to an ERISA plan administrator, it has failed to apprise the Court that the Sixth Circuit is the only court of appeals to do so, and that numerous federal circuits have come to the opposite conclusion. Courts in the First, Second, Fourth, Seventh, Eighth, Ninth and Tenth Circuits have held that language like that in the Policy is not sufficiently clear to grant discretion to an ERISA plan administrator.[39] Thus, the great weight of federal ERISA authority is contrary to Paul Revere's position.

II. It would be premature for this Court to consider this case before the Commissioner has had the opportunity to review the reasonableness of policy language that clearly grants an insurer discretion to make benefit determinations.

If this Court agrees to hear this case, it will be determining what effect the Policy language has on the review of Paul Revere's benefit decisions. As part of that decision, the

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[39] *Brigham v Sun Life of Canada,* 317 F3d 72, 81-82 (CA1 2003); *Kinstler v First Reliance Standard Life Ins Co,* 181 F3d 243, 251-252 (CA2 1999); *Gallagher v Reliance Standard Life Ins Co,* 305 F3d 264, 269-270 (CA4 2002); *Diaz v Prudential Ins Co of America,* 424 F3d 635 (CA7 2005); *Ferrari v Teachers Ins and Annuity Ass'n,* 278 F3d 801, 806 (CA8 2002); *Kearney v Standard Life Ins Co,* 175 F3d 1084, 1089-1090 (CA9 1999); *Nance v Sun Life Assur Co of Canada,* 294 F3d 1263, 1267-1268 (CA10 2002).

Court may, by implication, be deciding whether policy language granting an insurer discretion to make benefit determinations is permissible under Michigan law. If the Court decides that Paul Revere's policy does grant it discretion to deny claims, it will, by implication, be deciding that an insurer may reserve the discretion to decide whether the proof of loss received is "satisfactory." As this Court has recently held, that determination is reserved for the Commissioner of OFIS.[40] Until the Commissioner is presented with language that clearly vests discretion in the insurer and has the chance to review such language, this Court should not accept a case that may have the effect of proclaiming such provisions valid.

A. The Commissioner Has Primary Jurisdiction To Determine Whether Insurance Policies Are Reasonable.

The Commissioner has primary jurisdiction to determine whether an insurance policy that grants the insurer discretion to determine whether the proof of loss submitted is "satisfactory" is reasonable and allowable under the Michigan Insurance Code. "Primary jurisdiction 'is a concept of judicial deference and discretion.'"[41] The primary jurisdiction doctrine is rooted in the separation of powers.[42] It exists because of "the need for orderly and sensible coordination of the work of agencies and of courts."[43]

Primary jurisdiction applies whenever a claim requires resolution of an issue that has been placed under the regulatory authority of an administrative agency.[44] There is no formula for determining whether primary jurisdiction applies to a particular case.[45] Instead, a court

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[40] *Rory v Continental Ins Co,* 473 Mich 457, 475; 703 NW2d 23 (2005)
[41] *Rinaldo's Construction Corp v Michigan Bell Telephone Co,* 454 Mich 65, 70; 559 NW2d 647 (1997) (*quoting,* LeDuc, Michigan Administrative Law, § 10:43, p 70).
[42] *Travelers Insurance Co v Detroit Edison Co,* 465 Mich 185, 196; 631 NW2d 733 (2001).
[43] *Rinaldo's Construction Corp v Michigan Bell Telephone Co supra,* 454 Mich at 70 (*quoting,* LeDuc, Michigan Administrative Law, § 10:43, p 70).
[44] *Travelers Insurance Co v Detroit Edison Co, supra,* 465 Mich at 200.
[45] *Travelers Insurance Co v Detroit Edison Co, supra,* 465 Mich at 198.

should consider whether the reasons for the existence of the doctrine are present and whether the purpose of the doctrine will be served in the case before it.[46]

There are three principal reasons for application of primary jurisdiction.[47] First, a court should consider whether the agency possesses specialized or expert knowledge that will make it a preferable forum to address the issue presented.[48] Second, a court should consider the purpose of the administrative agency and refrain from making decisions that threaten the regulatory authority and integrity of the agency.[49] Third, a court should consider the need for uniform resolution of regulatory issues.[50]

The reasons underlying the doctrine make it clear that OFIS has primary jurisdiction to determine whether insurance policy terms are reasonable. First, OFIS possesses unique expertise on the question of what is, and what is not, reasonable. Its staff has tremendous experience with the industry, which provides insight into the potential results of various policy terms or limitations. Second, one of the main reasons for OFIS' existence is the regulation of insurance policies. If this Court were to enforce a policy provision purporting to grant insurers broad, new discretion to deny claims before OFIS had reviewed the reasonableness of such discretion, it would undermine OFIS' authority, as regulator, to prevent the issuance of policies that contain "exceptions or conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy."[51] Third, allowing OFIS to determine whether

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[46] *Travelers Insurance Co v Detroit Edison Co, supra,* 465 Mich at 198.
[47] *Travelers Insurance Co v Detroit Edison Co supra,* 465 Mich at 199.
[48] *Travelers Insurance Co v Detroit Edison Co supra,* 465 Mich at 198; *Rinaldo's Construction Corp v Michigan Bell Telephone Co supra,* 454 Mich at 71.
[49] *Travelers Insurance Co v Detroit Edison Co, supra,* 465 Mich at 199; *Rinaldo's Construction Corp v Michigan Bell Telephone Co, supra,* 454 Mich at 71.
[50] *Travelers Insurance Co v Detroit Edison Co, supra,* 465 Mich at 198; *Rinaldo's Construction Corp v Michigan Bell Telephone Co, supra,* 454 Mich at 71.
[51] MCL 500.2236(5).

policy limitations are reasonable promotes uniformity in the insurance industry. Thus, determining the reasonableness of policy terms, and limitations, is within the primary jurisdiction of OFIS.

Indeed, this Court has very recently confirmed that the reasonableness of insurance policy terms is within the primary jurisdiction of OFIS. In *Rory v Continental Ins Co,* this Court determined that "the Legislature has assigned the responsibility of evaluating the 'reasonableness' of an insurance contract to the person within the executive branch charged with reviewing and approving insurance policies: the Commissioner of Insurance."[52] The *Rory* decision went on to confirm that "courts have a very limited scope of review concerning the decisions made by the Commissioner."[53] Accordingly, it is OFIS that should determine whether insurers may reserve discretion to deny claims.

Until OFIS has had a chance to make a determination about the reasonableness of a policy provision that clearly expresses an intention to grant the insurer discretion to make benefit determinations, this Court should not accept review of a case which seeks to enforce such a limitation based on ambiguous contract language. To do so would undermine OFIS' ability to regulate insurers and involve this Court in matters that it has held are the province of the Commissioner.

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[52] *Rory v Continental Ins Co,* 473 Mich 457, 475; 703 NW2d 23 (2005).
[53] *Rory v Continental Ins Co, supra,* 473 Mich at 475.

Conclusion and Relief Sought

For the reasons set forth above, amicus curiae, Commissioner of the Office of Financial and Insurance Services, respectfully requests that this Court deny the application for leave to appeal in this matter.

Respectfully submitted,

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